VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 4, 2017

Ms. Mary Johnson, Administrator
Johnson Care Home
Po Box 190
Hancock, VT 05748

Dear Ms. Johnson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 6, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 01/03/2017
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0170	A. BUILDING: _____ B. WING _____	12/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON CARE HOME	PO BOX 190 HANCOCK, VT 05748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensure survey was completed on 12/6/16 by the Vermont Division of Licensing and Protection. The following regulatory violations were found.	R100	Addendum 12/6/16	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN (registered nurse) failed to assure that the care plan for each resident addressed all of their assessed needs for 1 of 3 residents in the total sample. (Resident #3). Findings include: Per record review, Resident #3 has decreased vision, with a total loss of vision in the left eye. The care plan failed to identify this need and provide effective interventions to facilitate the resident's needs. The RN confirmed the resident's visual impairment during interview.	R145	All residents are at risk, the RN will develop a written care plan that reflects each residents abilities and needs base on that clients Assessment. complete 1/25/17 RN and manager will review 2 residents every month and all residents will be reviewed every 90 days. 1/15/17 Resident #3 care plan has been ~~revise~~ corrected to include total loss of vision in her left eye. completed 12/27/16	
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6)	R149		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Green RN @ Johnson Care Home — TITLE — (X6) DATE: 12/28/16

STATE FORM 6899 LS9111 If continuation sheet: 1 of 4

Addendum for all responses per telephone call 1/4/17: The manager/designee will monitor all plans of correction for compliance.
R145 - R167 POCs accepted MBoltonRN/pmc, with addendum.

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R149	R149 Continued From page 1 Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to maintain an accurate and current list of medication orders, with documentation that the medication were given per orders, for 2 of 3 residents of the home. (Residents #1 and #3). Findings include: 1. Per record review, the physician orders for Resident #1 included ASA (aspirin) 325 MG. (milligrams) PO QID (four times daily) PRN (as needed), ordered on **11/1/15**. Per review the MAR did not include this current order. During interview, the RN owner stated that the physician had given a verbal order during a resident office visit to discontinue the aspirin order after the resident started on another pain relieving medication. The order was never documented and there was no policy/procedure for accepting verbal orders, per the RN. 2. Per record review, Resident #3's physician orders included Lorazepam, 0.5 mg. PO QHS (at the hour of sleep), ordered on 7/25/16. The order of 7/25/6 also included Lorazepam, 0.5 mg. PO PRN. Per review of the MAR for November, 2016, staff stopped the medication on 11/27/16 and there was a notation on the MAR that the order was discontinued on that date. There was no order found in the medical record to discontinue the Lorazepam.	R149	RN will assure residents medications orders will be complete and accurate. Manager and RN will develop a list of points, (order date, medication, dosage, freq, duration, etc) to monitor each order with. 1/15/17 RN will develop a Treatment list for each resident that includes name, date, treatment ordered, frequency and that Tx are carried out. 1/15/17 Resident #1 ASA 325mg PO, QID, PRN ordered was revised on Dec 13, 2016 completed Staff will be educated on the use of new Treatment sheet and monitor medication records, and review of medications with side effects. This is to be on going at each monthly staff meeting. 1/20/17 Resident #3 Lorazepam 0.5mg order was corrected and discontinued for both routine and PRN use on Dec 6, 2016 completed	

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R149	Continued From page 2 Refer also to R 167.	R149		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to develop a plan to address physician orders for PRN psychoactive medication administration for 1 applicable resident in the sample. (Resident #3). Findings include: Per record review, Resident #3 had physician orders for Lorazepam, 0.5 mg. PO PRN. There was no specific care plan to direct unlicensed staff to administer the medication that included a description of the behaviors the medication was intended to address, specified the circumstances when the medication could be given, and	R167	Resident #3 Lorazepam 0.5mg PO PRN is discontinued. 12/6/16 RN develop new documentation to administer PRN psychoactive medications with plan for there use. Plan and documentation describes the specific behavior the medication is intended to correct/address The side effects of the medication and to monitor for and the expected results. Education of staff to be done at staff meeting 1/20/17 At this time there is no PRN Psychoactive Medications.	

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R167	Continued From page 3 educated staff about what adverse side effects to monitor for and what the desired effects of the medication use are. Per interview with the home's RN, there were inconsistencies between the physician orders and the MAR (medication administration record) for the resident. The orders for Lorazepam, 0.5 mg. po PRN were dated 7/25/16 and there was no order in the medical record to discontinue the order. Staff had not recently administered the medication and the record noted that the order was discontinued on 11/27/16, however, no order was found to discontinue for this or any other date. Refer also to R 149	R167		